State of Illinois Department of Human Services
Home Services Program - Division of Rehabilitation Services

# Individual Provider Standards

Dear Customer,

During the eligibility determination process, it was determined you are capable of supervising an Individual Provider to assist you in your home. Individual Providers are defined as a Personal Assistant, Registered Nurse, Licensed Practical Nurse, Certified Nurse Assistant, Occupational Therapist, Physical Therapist and Speech Therapist. Your Service Plan identifies which types of Individual Providers will be used to meet your needs.

When customers use Individual Provider services, they are required to collect and certify the following information for each Individual Provider used. If you do not complete the information on this form and submit it before the Individual Provider begins employment, it may result in non-payment to the Individual Provider and ineligibility for further services for you.

**Please complete a separate form for each Individual Provider you use and submit with other required paperwork to your Home Services Program office**

1. Name: _____

2. Gender ☐ Male ☐ Female

3. Birthdate (MM/DD/YYYY): _____

4. Phone Number (include area code): _____

5. Legal Address
(Where the Individual Provider actually lives)

_____

_____

_____

6. Mailing Address
(Where the Individual Provider will receive his/her check)

_____

_____

_____

7. Individual Provider email address, if applicable, (for electronic correspondence such as timesheets and announcements):

_____

8. The Individual Provider is: (please check appropriate category)

| | |
|---|---|
| | 14 or 15 years of age and not employed during school hours, has an employment certificate and meets all other requirements of the Child Labor Law, and will be supervised by an adult 21 years or older |
| | 16 to 18 years of age and enrolled in school (must not be employed during school hours) |
| | 17 to 18 years of age and not enrolled in school |
| | an adult, 18 years of age or older |

9. The Individual Provider's preferred payment option is (please check one). If a selection is not made, the Individual Provider will automatically receive a paper check.

☐ Illinois Debit MasterCard® ☐ Direct Deposit into Bank Account ☐ Paper Check

10. If the Individual Provider is a CNA, LPN or RN, indicate hourly rate: _____

11. If the Individual Provider is a Personal Assistant, he/she has provided me with: (check one)

☐ Written or verbal recommendations from two current/former employers

☐ A referral from a Center for Independent Living (CIL)

☐ If never employed, written or verbal personal references from two non-family members

# Individual Provider Standards

12. The Individual Provider's previous experience and/or training are adequate and consistent with the specific tasks performed for me in my home as identified below:

| Task | Experience/Training |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

13. If the Individual Provider will perform incidental health care tasks, written permission has been obtained from my physician or another appropriate medical professional as approved by the Home Services Program.

☐ Not applicable ☐ Yes ☐ No

14. The Individual Provider has demonstrated a satisfactory understanding of Universal Precautions that will meet my needs.

☐ Yes ☐ No

15. The Individual Provider has provided the Home Services Program with a copy of his/her Social Security card or other documentation verifying this information.

☐ Yes ☐ No

16. The Individual Provider has provided the Home Services Program with a completed Employment Eligibility Verification form (I-9, U.S. Department of Justice) along with the required information that accompanies it.

☐ Yes ☐ No

17. The Individual Provider has received, completed and signed the Waiver Program Provider Agreement for Participation in the Illinois Medical Assistance Program form and will submit it to the Home Services Program office.

☐ Yes ☐ No

**Note**: PA and CNA complete the **HFS 1413B**. RN, LPN, OT, PT and ST complete the **HFS 1413A**.

I hereby certify the above information is true and accurate to the best of my knowledge. I further certify the Individual Provider named above has satisfactory communication skills and the physical capacity to meet my needs and he/she can satisfactorily follow directions in the completion of tasks performed.

I understand falsification of the above information by me may jeopardize payment to the Individual Provider and my receiving services through the Home Services Program.

| Customer | Parent, Guardian or Representative, as appropriate |
|---|---|
| Date | Date |

NAMES OF INDIVIDUAL PROVIDERS REFERRED TO CUSTOMERS BY THE DEPARTMENT OF HUMAN SERVICES - DIVISION OF REHABILITATION SERVICES SHOULD BE CONSIDERED AS POTENTIAL WORKERS AND NOT RECOMMENDATIONS TO USE THAT INDIVIDUAL. CUSTOMERS MAKE THE INDIVIDUAL PROVIDER(S) SELECTION AND SHOULD CHECK ALL REFERENCES/RECOMMENDATIONS PRIOR TO USING AN INDIVIDUAL.

# Individual Provider Standards

## Individual Provider Secondary Employment

The following information is required by all Individual Providers when enrolling as a worker and annually thereafter. Please accurately complete the form and return it as soon as possible to prevent delays in payment for services you have provided. Individual Providers must provide information for all other paid employment that he or she currently holds, including but not limited to other Home Services Program customers and other state-funded in-home care.

To be completed by the Individual Provider (include the days and hours worked):

Employer #1 Name: _____

Employer Address: _____

_____

Employer Telephone Number (include area code): _____ Date Started: _____

| | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Average Hours/Week |
|---|---|---|---|---|---|---|---|---|
| Start Time | | | | | | | | |
| End Time | | | | | | | | |

Employer #2 Name: _____

Employer Address: _____

_____

Employer Telephone Number (include area code): _____ Date Started: _____

| | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Average Hours/Week |
|---|---|---|---|---|---|---|---|---|
| Start Time | | | | | | | | |
| End Time | | | | | | | | |

Employer #3 Name: _____

Employer Address: _____

_____

Employer Telephone Number (include area code): _____ Date Started: _____

| | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Average Hours/Week |
|---|---|---|---|---|---|---|---|---|
| Start Time | | | | | | | | |
| End Time | | | | | | | | |

Employer #4 Name: _____

Employer Address: _____

_____

Employer Telephone Number (include area code): _____ Date Started: _____

| | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Average Hours/Week |
|---|---|---|---|---|---|---|---|---|
| Start Time | | | | | | | | |
| End Time | | | | | | | | |

I have no other employment at this time _____ Please Initial

_____
HSP Customer's Printed Name

_____ _____ _____
Individual Provider Printed Name Individual Provider Signature Date